Implementation of Assembly Bill 97

Implementation of Budget for FY 2011-2012

Today's meeting will address the implementation of AB 97:

- 10% Rate Reductions (including Pharmacy)
- "Soft Caps"
- Copayments
- Due to the complexity of the Long-term care reductions, it will be discussed in detail at another time.

Part 1: 10% Rate Reduction

Authority established by:

Welfare and Institutions Code, 14105.192

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14105.192 In State Fiscal Year 2011-12, Medi-Cal providers will receive an overall 10 percent ongoing reduction in reimbursement. DHCS will analyze and identify where reimbursement level can be reduced in accordance with standards required under the Section 1902 (a) (30) (A) of the Federal Social Security Act.

Welfare and Institutions Code, 14105.192.

- Payments for Managed health care plans that contract with DHCS shall be reduced by the actuarial equivalent amount of the payment reduction by contract amendments or change orders effective on *July 1, 2011*, or thereafter.
- This meeting is not intended to be a debate on actuarial soundness.
- AB 97 is the law.

Welfare and Institutions Code, 14105.192.

- It is the intent of the DHCS to implement the provider reductions retroactively to ***July 1, 2011***; however, only upon approval of CMS.
- State Plan Amendment (SPA) has been submitted to CMS.
- CMS response is pending.

14105.192. - 10% Rate Reduction

- The Director of DHCS shall adjust provider payments by up to 10 percent as specified for Medi-Cal Managed Care.
- The DHCS Director has discretion, adjusting the payments as specified with respect to one or more categories, products, services , or a combination, as long as the resulting reduction is in the aggregate total of no more than 10 percent.

Plan Questions/Concerns with the 10% Rate Reduction

- Which provider types will be affected?
- Pharmacy Concerns
- Will cuts be retroactive to 6/1?
- Will Medi-Cal fee schedule be revised?
- How will this be applied to outpatient hospital services?

Plan Questions/Concerns with the 10% Rate Reduction

- Concerns regarding transparency and sharing of rate methodology.
- Concerns regarding fiscal viability of COHS plans.
- Concerns about possible access issues

Approach: 10% Rate Reduction

What approach will DHCS take?

- Category of service level through a policy change factor – Approach is consistent with what was done in the past.

Approach: 10% Rate Reduction (cont.)

What categories of service are exempt?

- Hospice services and BCCTP.
- FPACT.
- Inpatient.
- FQHCs and Rural Health Clinics – there will be a managed care adjustment but clinics will be made whole through the FFS wrap around.
- DMH and DDS operated facilities.
- Payments funded through CPEs and IGTs.
- Other.

14105.192.- 10% Rate Reduction

- Due to the complexity of setting rates for the Medi-Cal Managed Care program, rates are subject to close supervision by U.S Department of Health and Human Services.
- DHCS is in the process of finalizing an access study and is in constant contact with CMS regarding the study.

Provider Payment Reductions (PPR)

- Methodology utilized in contract year 2011–2012 rates
  - 2009 base data was adjusted to replace prior PPR impacts

Calendar Year 2009 PPR Impacts								
	1/1/2009-2/28/2009	3/1/2009-4/5/2009	4/6/2009-12/31/2009	Weighted PPR	Needed CY2009 Adjustment		Current Factors	Final Program Change (rounded to 2 decimals)
Category of Service	**0.162**	**0.099**	**0.740**					
Inpatient Hospital	-2.832%	-2.832%	-2.832%	**-2.832%**	**2.915%**		**0.000%**	**2.91%**
Outpatient Facility	-8.500%	-0.850%	0.000%	**-1.458%**	**1.479%**		**0.000%**	**1.48%**
Emergency Room	-10.000%	-1.000%	0.000%	**-1.715%**	**1.745%**		**0.000%**	**1.74%**
Long Term Care	-1.496%	-0.748%	0.000%	**-0.316%**	**0.317%**		**0.000%**	**0.32%**
Lab and Rad	-3.800%	-1.000%	-1.000%	**-1.453%**	**1.474%**		**-1.000%**	**0.46%**
PCP	0.000%	-1.000%	-1.000%	**-0.838%**	**0.845%**		**-1.000%**	**-0.16%**
Specialists	0.000%	-1.000%	-1.000%	**-0.838%**	**0.845%**		**-1.000%**	**-0.16%**
Pharmacy	0.000%	0.000%	0.000%	**0.000%**	**0.000%**		**0.000%**	**0.00%**
FQHC Services	0.000%	-1.000%	-1.000%	**-0.838%**	**0.845%**		**-1.000%**	**-0.16%**
Other Professional	-3.200%	-1.000%	-1.000%	**-1.356%**	**1.374%**		**-1.000%**	**0.36%**
Transportation	-7.700%	-1.000%	-1.000%	**-2.083%**	**2.127%**		**-1.000%**	**1.11%**
All Other	-6.500%	-1.000%	-1.000%	**-1.889%**	**1.925%**		**-1.000%**	**0.91%**

Critical Dates			
Start Date	Days in Cycle	Distribution	Comments
1/1/2009	59	16.16%	12/31/2008 Factors are carried forward into 2009.
3/1/2009	36	9.86%	March 1st trailer bill reinstated the impact of injunctions from 8/18/2008 and 11/17/2008 and dropped PPR impacts from 10% to 5% or 1%.
4/6/2009	270	73.97%	Subsequent court decisions removed the OP, ER and LTC impacts.
4/13/2011			Elimination of PPR for IP.

BCCTP :	COHS BCCTP factors will only be 20% of these factors and no impact will be applied to either Two-Plan or GMC BCCTP.

Part 2: “Soft Caps”

Authority established by:

Welfare and Institutions Code, 14131.07(a).

Welfare and Institutions Code, 14131.07. (a)

14131.07. (a) Notwithstanding any other provision of this Chapter or Chapter 8 (commencing with Section 14200), the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that are a covered benefit under the Medi-Cal program shall be limited to seven visits per beneficiary per fiscal year.

14131.07. (a)- “Soft Caps”

- Applies to Both Fee for Service and Managed Care Plans.
- Adults with a covered benefit under the Medi-Cal program shall be limited to seven visits per beneficiary per fiscal year.
- Soft Cap is specific to physician services provided in an office, clinic, or in a hospital outpatient setting.
- ER visits are excluded.

Populations Exempt from the “Soft Caps” 14131.07.

- Children (aged 21 years and under),
- Pregnant women (14131.07.(d)) and
- Residents in Long-Term Care facilities (14131.07.(e))

Services Exempt from the “Soft Caps” 14131.07.

Services not subject to this 7 visit cap limit:

- Specialty Mental Health Services
- Any pregnancy-related visit as specified.

Services Exempt from the “Soft Caps” 14131.07.

The limit on physician office and clinic visits **DOES NOT INCLUDE:**

- A beneficiary under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
- A beneficiary receiving long-term care in a nursing facility.

Welfare and Institutions Code, 14131.07.

- It is the intent of the DHCS to implement the “soft caps” upon approval of CMS.

What does this mean?

- No retroactivity; no lead time to implement.
- State Plan Amendment (SPA) has been submitted to CMS.
- CMS response is pending.

Plan Questions/Concerns with "Soft Caps" Provision

- How does DHCS propose to implement, monitor and enforce the caps under Managed Care?
- Will the cap simply be a rate reduction and not an actual program change?
- How much of a rate reduction will the plans receive due to the expected diminished utilization related to the cap?

Plan Questions/Concerns with "Soft Caps" Provision

- Will plans be expected to amend provider contracts to require providers to track and cap services?
- Will DHCS take or expect enforcement action or do auditing related to the caps?
- How will the Department account for the seven (7) visit limit in managed care?
- Are Urgent Care and Behavioral Health visits subject to the seven (7) visit limit?

Plan Questions and Concerns with "Soft Caps" Provision

- Rates may be disproportionately reduced compared to a plan's ability to realize any medical expense savings through the implementation of the soft cap.

Approach: Soft Caps

What approach will DHCS take?

- Analysis of co-payments and soft caps needs to occur simultaneously as co-payments impact utilization.
- Analysis of the medical necessity of visits over the 7 limit.
- Requesting plans to submit data demonstrating the medical necessity.

Considerations and Approach: Soft Caps

- Direct Utilization impact to specified COSs
- Potential Unit Cost impact to those same COSs
- Potential indirect Utilization and Unit Cost impacts to other COSs
- Potential impact on Copayment change impact, and vise-versa
- Potential impact on MCO Administrative Percentage
- Requires analysis of detailed encounter data and potentially comparison to any ad hoc MCO-submitted financial data
- Requires consideration of sub-capitation arrangements

Part 3: Copayments

Authority established by:

Welfare and Institutions Code, 14134

14134. Copayments

Co-payments that Medi-Cal beneficiaries shall be required to pay are as follows:

- Up to $50 for non-emergency and emergency services received in an emergency room.
- Up to $100 for each hospital inpatient day, up to a maximum of $200 per admission.

14134. Copayments

- Up to $3 for each preferred and $5 for each non-preferred drug prescription or refill. “Preferred drug” is as defined in Section 1916 (A) of the Social Security Act.
- Up to $5 for each outpatient visit under subdivision (a) of Section 14132 including but not limited to physicians, hospitals, and outpatient clinics.

Welfare and Institutions Code, 14134.

- Implementation timeline is at the Director's discretion.
- Budget has a November 1, 2011 implementation date.
- Medi-Cal Managed Care ***is considering*** allowing plans sufficient lead time to implement [60-90 days].
- Waiver has been submitted to CMS.
- CMS response is pending.

Caveats to the Copayments in 14134.

- The co-payment amounts may be collected and retained or waived by the provider. However, as previously noted, the capitation rates paid to plans will be calculated assuming all co-payments are collected.
- If a Medi-Cal beneficiary does not pay the co-payment, the provider of service has no obligation to provide services (to the extent allowed by other provisions of law).

Caveats to the Copayments in 14134.

- If a provider provides the service without collecting the copayment and has not waived the copayment, the provider may hold the beneficiary liable for the amount of the co-payment.

Plan Questions/Concerns with the Copayments

- What services require copayments and what are the allowable copayment amounts by service?
- What are the limits to out-of-pocket costs for beneficiaries?
- Are emergency room copayments waived upon hospital admission?

Plan Questions/Concerns with the Copayments

- How long will health plans have to implement the addition of the copayments?
- How will DHCS account for variation in copayments among plans?

Plan Questions/Concerns with the Copayments

- Do copayments apply to all inpatient visits and beneficiaries residing in Long Term Care (LTC) facilities?
- Will the Department reduce rates for non-contracted hospital emergency inpatient services (i.e., Roger's rates) by the proposed impact of copayments?

Plan Questions/Concerns with the Copayments

- Concerns about copayments for high acuity (Level 5) Emergency Department (ED) visits and copayments for physician outpatient wellness visits.
- Concern that copayment amounts could add up quickly presenting financial hardship for members and become a disincentive to members' medically necessary care
- What will be the rate reduction due to copayments? How is this determined?

Considerations and Approach : Copayments

- Direct Utilization impact to specified COSs
- Direct Unit Cost impact to those same COSs
- Potential indirect Utilization and Unit Cost impacts to other COSs
- Potential impact on Soft Cap change impact, and vise-versa
- Potential impact on MCO Administrative percentage
- Requires analysis of rate-setting assumptions, potentially going back to detailed encounter data, RDTs and comparison to any ad hoc
  MCO-submitted financial data
- Requires consideration of sub-capitation arrangements

Part 4: Pharmacy

Authority established by:

Welfare and Institutions Code,
14105.33 - 14134.

Welfare and Institutions Code, 14105.33. - Pharmacy

- 14105.33 - Contracts shall provide for a state rebate, as defined, and would make conforming changes. It is the intent of the Legislature to enact legislation by August 1, 2011, that provides for the development of a new reimbursement methodology for pharmacy providers.

Welfare and Institutions Code, 14105.33. - Pharmacy

- This bill would, in relation to establishing the new reimbursement methodology, authorize DHCS to require providers, manufacturers, and wholesalers to submit any data the Director determines is necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition price.

14105.33. - Pharmacy

- Methodology change from average wholesale price to average acquisition price.
- Cost savings and increase in revenue from drug rebates.
- 14132. Elimination of non-legend acetaminophen-containing products, with the exception of children's acetaminophen-containing products.

14134. – Pharmacy Copayment

- Copayment of up to three dollars ($3) shall be made for each preferred drug prescription or refill. A copayment of up to five dollars ($5) shall be made for each non-preferred drug prescription or refill.

Plan Questions/Concerns with changes to Pharmacy

- How will the Department implement the 10% rate reduction for pharmacy services in managed care?
- Is the reduction for drug costs only, i.e., does not include the dispensing fee, or is it based in total unit cost, i.e., drug cost, dispensing fee?
- Is this for all drugs, preferred or non-preferred?
- Does “preferred/non-preferred” equate to “generic/brand” for managed care?

Plan Questions/Concerns with changes to Pharmacy

- How will the Department adjust each plan's revenue; Will the Department review each plan's formulary to determine which drugs are preferred/generic or preferred/brand?
- As the pharmacy co-payments may cause a shift toward increased generic use, how will this interact with the MAC pricing adjustment?
- What will the DHCS include in the elimination of nutritional supplements? Vitamins? Enterals?

Discussion

Closing Remarks